Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 12/14/11
Amount $2250.00

Evan Gray LLC 511255

I. **IDENTIFICATION**

Name Evan Gray, LLC dba: Florence Park Care Center

Address 6975 Burlington Pike.

City/County/Zip Florence, Ky 41042-1618

Telephone number 513-605-5001

Administrator Jeremy Yates

Date facility operation began at current address _____

Date facility began operation under current owner _____

II. **TYPE BEDS**	No. beds licensed	No. beds requested
Skilled	150	150
Nursing Home		
Nursing Facility		
Intermediate Care		
ICF/MR		
Personal Care		

II. **CONTROL** (check one in each column)

State	(Profit)	Individual
County	Nonprofit	Partnership
City		(Corporation)
(Private)		

II. **OWNERSHIP**

Name and address of individual owner, partners or corporation. If partnership, list partners.

Steve Boymel 100% owner
12500 Reed Hartman Hwy
Cincinnati, OH 45241

RECEIVED
DEC 14 2011
OFFICE OF INSPECTOR GENERAL

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation Burlington Realty, LLC.

Address of corporation 12500 Reed Hartman Hwy Cin, OH 45241

President or Chairman Steve Boymel

Vice President Greg Miller

Secretary Alex Boymel

Treasurer Jonas Boymel

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
	Health Care Management Group
	12500 Reed Hartman Hwy
	Cincinnati, OH 45241

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Allan Ochsen | CFO | 11-18-11

Signature of authorized representative | Title | Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)